



Temple Physical Therapy

230 George Street, 5th Floor
New Haven, Connecticut 06510
203.498.5980 Phone
203.498.5999 Fax

Name: _____ Date: _____

Address: _____ DOB: _____

Claim #: _____ Phone: _____

Age: _____ Height: _____ Weight: _____ Hand Dominance: R L Sex: M F

1. What is your exact medical diagnosis?

2. What is the date of injury?

3. What was your occupation at time of injury? Hours per day? How long?

4. How did the injury occur?

5. What was the date of surgery?

6. Are you currently working? Yes No If not, your last day of work was:

7. What is the name of employer?

8. What is your official job title?

9. Does your employer offer modified duty assignments? Y N

10. Do you have any physical restrictions/limitations that will prevent your return to work? Y N
If yes, please list:

11. What is your primary spoken language?

12. What is your highest completed education level?

13. Which assistive devices are you currently using?

Back Brace? Y N Tens Unit? Y N Cane? Y N Wrist Brace? Y N Other: _____

14. Please list all physicians who have treated or evaluated your injury.

15. When is your next doctor appointment?

16. What is the name and number to your attorney?

17. Do you have any residual problems from previous injuries?

18. Have you attended physical therapy or chiropractic Care? Y N
If yes, please list when this care began and the approximate number of treatments: